Nutrition Clinic Questionnaire

Name: _____ Height:_____ Weight:_____

Reason for visit: _____

1. Has your weight changed in the last six months? If so, how much?
   ☐ No change ☐ Lost_____ pounds in _____weeks ☐ Gained_____pounds in_____weeks

2. Are you currently following a special diet? ☐ Yes ☐ No
   If so, type of diet:_____ How long?_____

3. Have you ever received nutrition education from a Registered Dietitian? ☐ Yes ☐ No When?_____

4. Do you exercise? ☐ Yes ☐ No. If yes, how many times per week:_____ duration_____
   What type of exercise do you do? _____

5. Check which of the following conditions apply to you and list the medications you are taking:
   ☐ High Blood Pressure: Meds:_____
   ☐ High Cholesterol: Meds:_____
   ☐ Diabetes: Meds:_____
   Family History: ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes

6. Other meds: _____

7. Are you taking any over-the-counter supplements, to include vitamins/minerals/herbals? ☐ Yes ☐ No
   ☐ Multi-vitamin ☐ Other: _____

8. Do you have any food allergies/intolerances or cultural/religious food preferences? ☐ Yes ☐ No
   Describe: _____

9. Check all that apply:
   ☐GERD ☐Constipation ☐Diarrhea ☐Gas/Bloating ☐Trouble chewing ☐Difficulty swallowing

10. Do you smoke or use smokeless tobacco? ☐ Yes ☐ No What? _____ Packs/day? _____

11. Do you drink alcohol? ☐ Yes ☐ No What? _____ Amount _____ /day _____/week

DIET HISTORY:

1. How many meals do you eat per day?_____. Do you eat snacks between meals? ☐ Yes ☐ No
   If yes, what type of foods do you snack on?_____

2. How do you cook most of your foods? ☐ Fry ☐ Bake ☐ Grill ☐ Convenience ☐ I don't cook

3. Who does the grocery shopping and cooking? ☐Self ☐Other _____ ☐Don't shop

4. How many times do you eat/take out per week? _____ Which meal(s)? _____
   Type of restaurants? _____

5. What type of beverages do you drink?

Item	Amt/day	Amt/week	Item	Amt.day	Amt/week
Regular Soda	_____	_____	Milk (type:_____)	_____	_____
Diet Soda	_____	_____	100% Juice	_____	_____
Water	_____	_____	Fruit Drinks/Koolaid	_____	_____
Tea	_____	_____	Crystal Light	_____	_____
Coffee	_____	_____	Sports Drinks	_____	_____
Beer/Wine/Liquor	_____	_____	Other _____	_____	_____

6. If you did not keep a food record please write down everything you ate and drank in the last 24 hours. Please include portion sizes, condiments, and beverages:

Breakfast Mid Morning Snack Lunch

Afternoon Snack Dinner Bed Time Snack

COMPLETED BY DIETITIAN / DIET TECHNICIAN

BMI _____ REE _____ x Activity _____ = _____kcal/day to maintain

Estimated energy needs to gain/lose:_____